Nursing with a Message

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Chapter 3

Practicing Nursing Knowledge

By 1931, supporters of the new Nursing Service had a consistent message that it sent to the Rockefeller Foundation in support of its practice and teaching missions. Grace Anderson, in her report to the Foundation on the work of its Teaching Service, spoke directly to its significant success in "pooling of professional knowledge and skills in working out the essentials of a family health program for the community." Only in East Harlem—and, she argued, nowhere else in the country—could observation and practice be directly correlated with theoretical instruction in education, psychology, sociology, nutrition, mental hygiene, and social casework. Its students from around the globe learned about family relationships in class and focused on improving them in practice. It provided its students with a "social laboratory" in which experiences were translated into new principles and practices.[1] And rather than reporting their prenatal and health work with mothers, infants, and children as separate categories, Anderson spoke more directly to their work with families as a whole.

Homer Folks also carried a similar message to the Foundation. As he wrote Thomas B. Appleget, the Foundation vice president to whom the Service now reported, it was now a successful "family service." Its success lay in its specific recognition "that public health nursing is a complex undertaking which must derive many of its techniques from specialists in other fields." The teaching and supervisory staff at the Service now included nutritionists, mental hygiene specialists, social workers, teachers, and physicians. Mindful of the Foundation's concern about where and how a public health nurse should be educated, he also noted the strategic position of a fully trained nurse. Through calls from mothers seeking prenatal care for themselves or home nursing for sick

children, such a nurse reached "a cross-section of the community—families that would not be known to other agencies."[2] He reemphasized this in 1932, calling attention to the increasing interdisciplinary nature of the family service. "The Nursing and Health Service has disregarded the barriers that exist between professional groups," he wrote, "and has brought experts in nutrition work, in mental hygiene, in social work, and in education into a close working relationship with nurses and physicians to the end that a more complete service may be rendered to the people of the community."[3]

On one level, this chapter explores the knowledge needed for this reworked notion of public health nursing practice. Some, such as the knowledge required for generalized public health nursing practice, had long fallen within nursing's domain. Other kinds involved knowledge relocations as messages about health and illness became more normalized and standardized. Supported by additional funding from the Milbank Memorial Fund, for example, the Bellevue-Yorkville Demonstration Project charged two public health nurses with developing health education curricular materials that the city's public and parochial school teachers would incorporate into their own lesson plans, freeing up time for these schools' own nurses to incorporate vision tests, formerly the purview of physicians, into their own practices. And still others involved incorporating new knowledge, particularly that associated with the mental hygiene movement, into extant disciplinary practices.

But this chapter is about more than the knowledge required for health work. It is also about how ideas about health circulated between and among constituents, how they were implemented, and how their implementation fed back into new policies and practices. At the Bellevue-Yorkville Demonstration Project, for example, the relationships were fairly straightforward. In conjunction with the Department of Health, it had also prioritized health initiatives, particularly those promoting the periodic medical exams. It hoped its medically rich environment would provide the support and the resources necessary for this campaign. The Bellevue-Yorkville Project fought hard: It invited local private practitioners to the center to learn about and practice this new medical procedure; it sent nurses into their offices to educate their patients; and it offered laboratory services for specimen analyses that were part of a comprehensive health exam. The Project, however, failed: Physicians remained skeptical about a practice for which they had received no training in medical school; and patients remained suspicious that this was just another way for physicians to extort more fees.[4]

At the East Harlem Nursing and Health Service, however, the relationships were more complicated. These nurses, like other progressive urban colleagues

throughout the country, used their practice experiences to move to legitimizing their claims to families as their exclusive domain. They built knowledge that bridged the biological sciences that supported their public health practices with the new knowledge in the social sciences that buttressed their work with families. This practice, however, brought them out of bounded disciplinary interests and into a place at the center of not only their own but also others' agendas. Foundations, families, physicians, and other public health workers all had particular ideas about what nurses should and could do as they delivered their messages of health. Indeed, the Service's nurses practiced in a very complicated space of ideas, practice, action, and actors. It locates the problems of coordination within disciplinary tensions as nurses and social workers—working within a web of gender, class, race, and power—sought to advance their own disciplinary interests even as they searched for better ways to care for the families in their charge. The knowledge they needed for practice was contingent, determined not just by the needs of its and other disciplines but also by the demands of the community it sought to serve.

Knowledge for Practice

In 1926, the Nursing Project formally published its research on the comparative effectiveness and costs of generalized and specialized public health nursing services. This pamphlet also included an appendix that described a six- to eight-week period of staff orientation to and education for generalized nursing practice where one nurse attended to all the health and illness needs of a defined neighborhood. But in 1926 and carried through to its 1928 reinvention as the East Harlem Nursing and Health Service, it could hire what many other public health nursing agencies could not—it could choose among experienced white public health nurses.[5] The Service's silence, however, on the backgrounds of those white nurses new to its practice does speak to its privileged place within the city's public health nursing community—and, indeed, the very privilege of whiteness within its tight circle. East Harlem worked within an assumption of white competence.

Black public health nurses could not. A 1928 press release generated by the Association for Improving the Conditions of the Poor (AICP) about the black-nurse-managed Health Center at Columbus Hill needed to carefully elucidate these women's impressive backgrounds. Their supervisor, Sadie Stewart Hobday, first trained as a teacher at the Hampton Institute, then attended the Lincoln Hospital Training School in New York City, and practiced public health nursing in Tulsa, Oklahoma, where she wrote about building the city's own black health center for *Public Health Nurse.* In 1927, Hobday had returned

to New York City where she worked with four other nurses who shared connections to the Lincoln Hospital Training School, the black Harlem Hospital, and postgraduate training at the Henry Street Visiting Nurse Service. Education stood as a proxy for class and class mattered for respectable practice, irrespective of race.[6]

But within the segregated norms of the city's public health practices, class, race, and gender continued to intersect in complicated ways. Both the East Harlem Nursing Service and Columbus Hill Health Center used volunteers, but those at the Service were women from the community who helped the nurses navigate issues of language and customs among its Italian American families. Volunteers at Columbus Hill, by contrast, were not from its British West Indian community. Rather, they were married graduate nurses who certainly would have added valued services. But most importantly, their presence enacted norms of middle-class black domestic respectability in which wives did not need to work for money to a poorer community in which mothers—too often, in their nurses' eyes, single mothers—had to work to support their children.[7] That these nurses were women mattered as well. Only black nurses could represent black middle-class respectability. The AICP, working through Columbus Hill, would not hire any formally trained black social workers, preferring to use untrained black "field workers" and "visitors" to do its social welfare work.[8]

Whether at East Harlem or in Columbus Hill, whether for nurses new to public health nursing or moving from specialty to generalized practice, the East Harlem Nursing and Health Service recommended that knowledge for generalized nursing practice began with a study of the families in a particular community. During their first week, nurses new to East Harlem learned about the Nursing Service's mission, wrote their impressions of the community, and began practicing with nurses, answering calls to provide bedside nursing care to sick individuals. This seemed the easiest way to draw on the knowledge that hospital-trained nurses already knew and to move them toward two goals: beginning to think about individuals in the context of their families; and integrating the knowledge that brought nutritional, mental hygiene, and tuberculosis care into their practices. By 1928, Grace Anderson had also added statistical knowledge to the public health nurse's repertoire. This kind of knowledge, she argued, helped the nurse find and, more importantly, interpret data circulating about the health of their communities. Remember, she cautioned, to use care when interpreting trends in morbidity and mortality rates; it would be quite "dangerous" to draw conclusions about particular conditions that included only a small number of cases since clinically insignificant variations could dramatically skew results.[9]

Data collected and systemized by public health nurses, in fact, drove many public health databases. And, Anderson admitted, the extensive, if not exhaustive, systems of recordkeeping in public health nursing practices remained "a much debated point." Statistics, favored by public health reformers and demanded by the philanthropies that supported New York City's health demonstration projects, existed at an uneasy intersection of knowledge and perception. Matthias Nicoll, the commissioner of New York State's Department of Health, advised the Milbank Memorial Fund in 1924 to remember when thinking about the outcomes of its three demonstration projects in the state, that "statistics don't demonstrate." Neither do they "have any effect at all when it comes to a consideration of what that means to the average man in taxes." In fact, Nicoll concluded, "I think he is going to look at his tax bill and take his chance on death."[10]

Similarly, Anderson's nurses looked at the enormous amount of time and energy that went into creating and maintaining data and wanted to take their chance to have more time with patients. They had to create individual files that were cross-indexed with family files. They had to complete separate forms for their maternity visits as well as visits to preschool children, sick individuals, and those patients with tuberculosis. At the end of each day, they had to create their own daily reports on home visits and those in the clinics they conducted at the Service. These data, in turn, fed forms for monthly reports that fed forms for quarterly and annual ones.[11] Anderson's nesting of statistics as important new and scientific knowledge for public health nursing practice hoped to reframe this tedium. It followed a long tradition of reimaging practice through the lens of knowledge. "How hopelessly dull, not to say irritating," Isabel Hampton Robb, a leading training school superintendent of nurses, had admitted in 1903, "would be the many washings and various aseptic precautions which are now required from the nurse . . . unless she had learned from bacteriology to appreciate the fact that there exists a surgical, microscopic cleanliness."[12] A quarter century later, Anderson wondered, is not our direct care of patients so much better when driven by data rather than subjective impressions?[13]

Data also drove the next two weeks of training in maternity nursing: data on the mothers themselves, their places of delivery, maternal mortality, infant mortality, and breastfeeding rates. Maternity nursing was also imagined as a practice that would support a fuller transition to family nursing by concentrating on the mother-infant dyad. But the knowledge needed for this practice was not new knowledge, although it may have been new to some nurses. Required readings such as T. W. Galloway's *Love and Marriage* and Carolyn Conant Van Blarcom's *Getting Ready to Be a Mother* were texts already circulating among middle-class

wives and mothers. This practice was to be an instance of knowledge transfer, but now from public health nurses to poorer women.[14] This process had limitations. *Love and Marriage* prepared nurses to walk new wives through "conditions" for a successful marriage that included "normal" sexual relationships without any acknowledgment of the social, cultural, and faith traditions that had an equally powerful effect.[15] And East Harlem nurses were quite critical of those traditions in its Italian and Italian American community. They believed that wives were simply passed from homes dominated by fathers to those dominated by their husbands; that they were "handicapped" by too frequent pregnancies; and that their social life was "restricted" to events involving their local churches. The Service's primary goal was to ensure a safe maternity for both mother and newborn infant. But it also took seriously its commitment to "broaden" the mother's "social contacts." To this end, it created prenatal and sewing classes at the Service that provided both educational and recreational resources.[16]

Van Blarkom, a 1901 graduate of the Johns Hopkins Training School for Nurses, became interested in midwifery through her national work on the prevention of blindness: Her own earlier survey of midwifery practices in Europe convinced her that US midwives' failure to use silver nitrate contributed to the place of *ophthalmia neonatorum* as one of the leading causes of blindness in the United States. Her campaign to regulate midwifery practice led to her own position as the first US nurse to also be a licensed midwife and to the founding, with others at Maternity Center Association (MCA), of the first midwifery school at Bellevue Hospital in 1911. Because of her ties to Bellevue and MCA, *Getting Ready* at least acknowledged that mothers crossed socioeconomic (but not race) classes. Often her recommendations on the need for corsets for an expanding abdomen or supports for milk-heavy breasts also contained instructions (with pictures from the MCA's own collections) on how they might be fashioned from materials in one's home.

Van Blarcom did write elsewhere directly for nurses. Her popular *Obstetrical Nursing*, first published in 1922, subsequently went through three editions.[17] But in choosing the lay *Getting Ready to Be a Mother* for the education of its own public health nurses, the leaders of the East Harlem Nursing and Health Service delivered a powerful message of the kinds of knowledge it valued. Public health nurses had long considered themselves and had been considered by others as the "connecting link"—between patients and physicians, between and among institutions, and between scientific knowledge and its implementation in the homes they visited.[18] Now they were to be the "connecting link" between the knowledge easily accessed by middle-class mothers and that needed by poorer ones. *Getting Ready* contained all the standard

prenatal instructions that a physician would give his middle-class patient. It discussed the importance of regular exams to measure the growing child; about the problems (and the solutions to those problems) that might be experienced during pregnancy. It spoke to the need for healthy diets, fresh air, rest, dental care, a cheerful and hopeful frame of mind, a safe and sanitary room for a home delivery. And it concluded with the importance of a carefully structured infant routine, built around regularized times to breast-feed in laying the foundation for the development of a strong and independent adult.

East Harlem's plan to orient to and educate for generalized public health nursing practice allowed its nurses, during their fourth week, to work with experienced nurses on home visits that would consolidate their knowledge and techniques, particularly the bag techniques, that differed according to types of cases. Week four, however, did set aside time for a special class on social casework that would help nurses better understand the social problems some families they had visited experienced. By week five, the nurses had moved on to the care of infants at home.[19] Much of the material they covered overlapped with Van Blarcom's advice, but, increasingly, East Harlem's nurses focused on specific developmental outcomes. This included bowel training at three months, weaning at six months, and bladder control training beginning at any point from six to twelve months. And they noted with pride that many of their babies were out of diapers at nine months.[20] Like Van Blarcom, they both deplored "artificial feeding" as a leading cause of malnutrition and devoted pages to how to instruct mothers in the proper preparation and storage of formulas. They also took the prevention of the development of rickets as a particular issue, concerned that it caused the childhood pneumonias that represented the greatest demand on their bedside nursing service. Rickets, a softening of the growth plates at the end of a child's bones that led to deformities such as bowed legs, had been rampant among poor, urban children at the turn of the twentieth century. But by the early 1920s, researchers had established the value of cod-liver oil and sunlight in its treatment and prevention.[21] And both the AICP and the nurses in East Harlem remained determined to distribute cod-liver oil and to preach the value of play in bright sunlight to all the infants in their charge.[22]

The final week—one that concentrated on working with preschool children—represented the culmination of all that a family nursing service represented. Remember, the nurses learned, that "everything" affects the well-being of these children: the mother and a newborn child; any illnesses in the family; parental employment (or lack thereof); whether children in the home worked to support the family's finances; and the stability of family, particularly marital, relationships.[23] This practice tested all of a public health nurse's

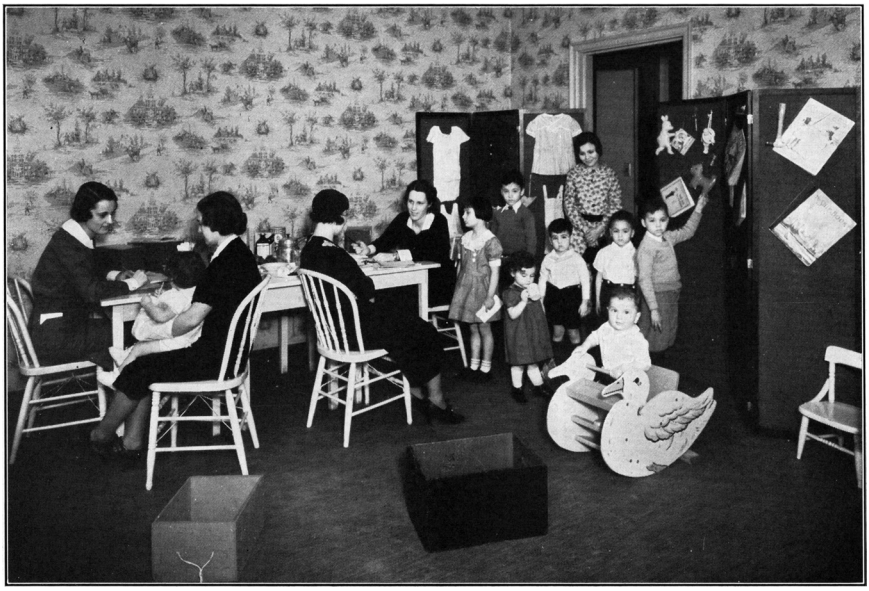

Figure 4. The Parents Conference Room at the East Harlem Nursing and Health Service
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accumulated knowledge of nutrition; normal childhood growth and development; habit training in independence, self-control, and obedience; and of how best to advise parents in handling their children's temper tantrums and bedwetting.[24] It also tested her more traditional public health knowledge in promoting vaccinations and immunizations in families with young children and in helping parents negotiate various medical and social services as they sought to correct such identified "defects" as dental caries, infected tonsils and adenoids, and infections of the ears, eyes, and skin. Many parents seemed to have found this kind of public health nursing useful. By 1928, Anderson claimed to have reached 40 percent of East Harlem's preschool children and, over the course of the demonstration, provided more than four thousand discrete services. Indeed, she continued, the problem was not in "finding" these children at home with their mothers; the problem was in "selecting" those children and families who could most benefit from among the many more who sought its service.[25]

Practicing Family Nursing

At the same time, Anderson also found herself constantly balancing a commitment to generalized nursing with the need to administer clinics organized around the medical specialties of the physicians who staffed them. Anderson tried as much as possible to rotate her staff weekly through the Service's six

infant clinics, three preschool clinics, six tuberculosis clinics, and six general medicine clinics to maintain their generalist knowledge base, but issues of timing, expertise, and personal preferences presented constant challenges.[26] But, as she wrote in 1934, it was worth it. "Because of its flexible program, freedom in experimentation, and its long-time contacts with families and individuals," the Service did not need to restrict its mission to only one purpose, as did the city's private visiting nurse agencies who cared for ill individuals in their homes. Nor did it have to deal with the more rigid administrative structures and bureaucracies of the city's Public Health Nursing Bureau. Hence, she concluded: the need. "The Nursing and Health Service offers a type of community service that can only be given by a private or voluntary agency."[27]

Irrespective of the families' wishes, the Service considered itself responsible for all the families it served until they moved out of the district. It had created a new "midway file" for those no longer needing home visits but still needing clinic assistance for routine physical exams or particular tests for suspected cardiac, venereal, or infectious diseases. Advancement to the midway file also spoke to a moral decision made about the family by the Service. Such a parent had assumed responsibility for helping her (and it was almost entirely "her") family; its children were thriving; and she only needed reminders about upcoming classes and clinics.[28] It should be noted, however, that not all families were treated equally. The nurses at East Harlem, believing that the "informed intelligence" of parents was key to their health work, selected young parents with either their first or only a few children and who showed "promise of an ability to learn new ways" for more intensive educational health work.[29] Given the community's demographics, these were likely to be second-generation families.

Families of East Harlem

Its children, however, looking back at their and their families' experiences in East Harlem, seemed much more ambivalent about what the Service wanted to provide. Leonard Covello, an educator deeply involved with Italian American students both in East Harlem high schools and at Columbia University's Casa Italiana, had assigned his college students in the 1930s the task of collecting memories and impressions of East Harlem in earlier years. Covello, who had immigrated to East Harlem in 1896 from Southern Italy as a young child with his family, was a leader in New York City's intercultural education movement who also had an abiding interest in helping his students to simultaneously Americanize while remaining proud of their Italian heritage. The research of his students painted a different picture of East Harlem than the one the public health nurses had internalized.[30]

These informants spoke to a more nuanced sense of community, differentiating the needs and aspirations of those arriving before World War I and those arriving after. Those that came in the early twentieth century had fled the poverty of small towns and farms. They had never experienced urban life. But those that came after the war but before the final immigration caps of 1921 and 1924 had been "dragged by war from place to place" as officers in the Italian army, had "opportunities to improve their minds" and seemed more educated and sophisticated. They were a professional group, more interested in improving neighborhood conditions and much less interested in the "noisy and colorful religious celebrations" and the "antiquated . . . and in most cases useless associations" that had formed the fabric of East Harlem's social life.[31]

Death did seem to pervade their lives, and they spoke movingly of their own experiences of the deaths of parents and of children. "My father's death," one recalled, "were [*sic*] the periods of my greatest crisis. I thought things would never go straight because the supporter of my family had gone to rest." Yet another remembered that "the worst experience I had as I look back upon them even now is the deaths of my two brothers and mother."[32] They sought consolation in the mutual aid societies they created. East Harlem alone was home to more than 250 such societies. These societies, it seemed, rarely lived up to their promise of help with medical expenses. But they did allow an older generation to place their "health, their lives, and their material fortune in the hands of a benevolent saint without which, for the elders, life would seem impossible." More pragmatically, they also provided for the costs of a "dignified burial," mitigating a "constant fear" that now in the United States a new generation of relatives "might let their traditional duties slip."[33]

Yet concerns about their health did not figure prominently. Most believed themselves to be "sturdy" and "endowed with a strong constitution."[34] They believed in the efficacy of their own or their friends' remedies for "minor illnesses." And they believed in the place of traditional beliefs and practices in the face of scientific evidence. Italian mothers, another informant reported, believed that children, like animals, knew instinctively what is good for them by its taste and would never force them to drink something "strange or disagreeable."[35] The nurses in East Harlem, it seemed, faced a particular challenge when urging mothers to give their children cod-liver oil to prevent rickets.

They faced a similar challenge when urging families to practice healthful habits. As at Bellevue-Yorkville, schools had become an important nexus for the dissemination of health practice education. Yet a "painful contrast" remained. "The teacher said, for instance," one informant remembered, "that clean hands, clean clothing, and a toothbrush are essentials; or that plenty of

milk should be taken in the morning." Yet, while not rejecting such messages, inertia set in when trying to translate such instructions into the fabric of family life. "But the father comes home from work, and the mother at her household tasks though they may not oppose the rules, they do not necessarily exemplify them at home."[36]

Families played a seemingly more direct role in decisions to follow the East Harlem nurses' exhortations to seek dental care for their children. One of Covello's students, Alice Kraus, felt the problem of families and dental care was twofold. The first involved the fact that East Harlem families came from rural settings with hard bread as a diet staple. Hard bread seemed to obviate the need for dental care in Italy, but now these families had settled in a city and country "which has one of the highest ratings in the world for dental caries." The second involved the parents' own experiences. These parents—with no tradition of routine dental care—waited to seek treatment "until the pain has practically pushed them into the dental chair." As any good parent, they "feel they are protecting their children against possible pain if they prevent them from attending the (dental) clinic."[37]

Like many ethnic communities, the Italian American community in East Harlem prided itself on its ability to support a hospital for its most destitute members. The Italian Hospital of New York City had initially opened in East Harlem in 1891: It was "small and unpretentious" and its nursing care (indeed all the care, including that of pharmacists and lab technicians) was provided by the Missionary Sisters of the Sacred Heart, an Italian nursing order founded by Francesca (Frances) Cabrini, which also ran hospitals in other cities in the United States with sizable Italian populations. The Italian Hospital soon moved downtown to the Lower East Side, another poor and overcrowded area of the city with a larger Italian population. By 1928, however, when the demonstration project converted to a Nursing Service, plans were in motion to build a new hospital, "an imposing and monumental structure," in East Harlem where patients could find their care delivered "in their mother tongue." But the new hospital would not be for those interviewed in East Harlem: it would be for others. A deep suspicion of hospitals fused with the community's sense of themselves as "sturdy." In the hospital, one 1905 commentator noted, "they say you can't kill an Italian."[38] Yet the Italian American community recognized that a hospital represented more than a way to care for its most destitute members, that it was critically important to its community of Italian American physicians. It meant, as one physician noted, that it provided "incalculable advantages" to a new generation of Italian physicians shut out from practice privileges at the city's more prominent medical institutions.[39]

This deep-seated sense of marginalization pervaded memories. Covello himself described his own feelings of "hurt" at the barriers to full inclusion in the American dream he felt as both a child and a young adult in East Harlem. Although he had later come to understand "that none of these hurts were deliberate"—that they were the unfortunate results of a failure on everyone's part to understand each other—other data suggested he was being unduly charitable.[40] A 1933 series of brief "on the street" surveys of New York City's attitudes toward Italians found them described as "wops," and characterized as "greasy," "dirty," and "destructive."[41] These attitudes found their fullest expression in the East Harlem public schools. At best, one informant remembered, "being Italian was virtually a faux-pas and the genteel American ladies who were our teachers were tactful enough to overlook our error."[42] At its worst, the relationship between students and East Harlem children—particularly its boys—were characterized by mutual contempt. Boys, another recalled, would be deliberately "rebellious" to a female teacher who found it "no small task to come each morning to try to pound ideas into a bunch of little garlic eating greasers." School, he remembered, was conducted in an atmosphere of "bitter opposition and intense conflict."[43]

And schools, Covello wrote, seemed to fail families, as well. Too often, he continued, they refused to give families "even the courtesy that may rightly be expected," and tolerated teachers who "take refuge for their own insufficiency" in disparaging comments about the community.[44] Covello was particularly interested in positioning schools as a "coordinating agency" that might meet a broad array of social, health, and hygiene needs. In his vision, families and schools mutually shared responsibility for and participation in the community's health and well-being. But first, those participating in working toward this particular vision needed to understand "EXISTING ATTITUDES." They needed to recognize that in East Harlem many families opposed taking medicines, were afraid of hospitals, did not fully understand advances in medical science, and must be educated in their own language and in ways that do not "overburden them." But, most importantly, health education had to be dissociated from social welfare and charity work. It had to come into schools where it would instead be identified with "common sense, general education, and the ordinary routines of school, home, and community life."[45]

Covello's vision, of course, fit within the long history of parent education as a social movement in the United States. Its more organized form had begun with the earlier twentieth-century efforts to organize mothers in a common cause around what would become the Parent Teacher Association. It changed during the 1920s as new insights from the social and behavioral sciences fused

interests in parent education and the needs of the preschool child. As historian Steven Schlossman has argued, this new movement stressed "the plasticity of early childhood and the irreversibility of character traits instilled then." In keeping with this new knowledge, East Harlem nurses' emphasis on teaching families how to instill regularity and routine into the lives of their infants and preschool children was to prevent the "maladjustments" that would eventually produce emotionally immature and socially irresponsible adults.[46] But, Schlossman continues, by the 1920s, parent education initiatives also moved away from an earlier generation's interest in engaging poor families to focusing on middle-class ones.[47] This left a void that public health nurses and also social workers associated with charity work tried to fill. And neither Leonard Covello nor many families in East Harlem trusted social workers.

Covello was particularly strident. Social workers, he preached, must treat Italians and Italian Americans as "NORMAL HUMAN BEINGS." They must understand the norms and values of traditional Italian families, ones that emphasized the solidarity of the family and the respect shown to elders whose words had the effect of "law." Social workers needed to drop their focus on the "pathological" and understand the "stress" of unemployment, serious illness, and, above all else, their children's transition to school where American values of individualism and choice collided with tradition norms of duty and responsibility to family. Social workers, in the end, needed a "deliberate rearrangement" of their attitudes.[48]

East Harlem families shared Covello's sentiments. They resented "even well-meaning attempts" to help poorer families access material resources because they believed it drew on a wellspring of assumptions that all Italian families were poor.[49] They also believed social workers intrusive. One informant told a story of a social worker who took it upon herself to throw a disabled husband out of his home with a warning that he could not return until he had found employment.[50] And they actively protected their own power. When another East Harlem mother was summoned to a school to explain why her fifteen-year-old son had to work rather than attend classes, she made it known that she had to be present at all follow-up interviews. As she explained, she would not have her son "exposed to the influence of the social worker without the benefit of his mother's judgment."[51]

Social workers lived this legacy of suspicion. Their work in the 1920s demanded intrusion into private family matters as they believed they needed to know the family's history, its current needs, and its potential for future independence through the "adjustments" they would bring to bear.[52] This was the territory that public health nurses sought to enter. At East Harlem, this required not only a change in focus, but also one in methods: Traditional public health

nursing checklists had evolved into narrative Family Date Sheets transcribed by stenographers; and health clinics and conferences at the center would become places where a mother would bring all her children at one time rather than sequentially to identified infant or preschool health screenings. But, most of all, it meant more aggressively promoting the mental hygiene aspects of the new family nursing role to a wider audience. Lillian Wald was reportedly "a little afraid" of this change: it would make the nurse "a thorough welfare agent."[53] Or, in other words, it would make a nurse a social worker.

Nursing and Social Work

Public health nurses and social workers had a long and often tangled history. Both groups of predominantly women clinicians came of age in the early twentieth century's Progressive era concerns that the increasingly reductionist and impersonal medical emphasis on the patient's body completely ignored the social and environmental determinants of health and wellness. The response had been the creation of social service departments in larger and more progressive hospitals that would consider the patient as a person with real social, environmental, and economic needs. And, ideally, it would be nurses who would staff such departments. Slowly, the idea of women in social service to the sick and the dispossessed took hold.

The boundaries between the work of nurses and that of social workers remained quite fluid in the early decades of the twentieth century. Indeed, the settlement house movement seemed to completely collapse such boundaries. Lillian Wald, for example, trained as a nurse, but her commitment to reform placed her work within the tradition of social work service. Jane Addams, the head of the equally renowned Hull House in Chicago, had no healthcare background, but her realization of the role that health and illness played in the ability of immigrants to secure a firm foothold in the American experience led to the creation of weekly health clinic services for the residents of her community. Ida B. Cannon, a nurse with experience investigating the living conditions of individuals with tuberculosis in early twentieth-century Boston, established one of the first formal hospital social service departments at the Massachusetts General Hospital.[54]

Yet, Cannon, like many other Progressive-era social workers, felt a compelling need to differentiate her work from that of nurses, on the one hand, and that of religious orders and individuals doing private charity work, on the other. These social workers grounded their work in the newly developing social sciences, established schools of social work and philanthropy, and, with the 1917 publication of Mary E. Richmond's landmark book, *Social Diagnosis*,

laid claim to the specialized knowledge and investigative procedures that established "casework" as their unique, professional contribution to the health and well-being of individuals and families.

Like nurses, social workers struggled to get other professionals to recognize their claims.[55] In his famous 1915 address, "Is Social Work a Profession?," Abraham Flexner told social workers assembled at Baltimore's National Conference of Charities and Correction that they were more akin to trained nurses: They were both "twilight cases."[56] Flexner's opinion mattered. He was the author of the influential 1910 Carnegie Foundation report on medical education in the United States and Canada.[57] This report galvanized public and philanthropic support for medical education reform and research; and Flexner was currently serving on the Rockefeller Foundation's General Education Board, setting policies in place that would ultimately transform not only the ways in which physicians were educated but also their place at the apex of social and professional status. In his mind, both social workers and trained nurses, however valuable their work, served in a "mediating" rather than an independent capacity. They both worked through others—physicians for health, legislators for reform—to achieve their ends.[58] The public health nurse, on the other hand, seemed closer to professional status. Flexner believed her to be a "sanitary official, busy in the field largely on her own responsibility rather than in the sick room under orders." Indeed, he wondered whether the title "nurse" appropriately described her role and ventured to predict that term would change as public health nursing matured as a field.[59]

The resurgence of the mental hygiene movement in the 1920s offered a potentially new knowledge base—that of psychoanalytical theory—that both social workers and nurses hoped would buttress their claims to specialized knowledge and independent practice, the two criteria that Flexner believed compromised their claims to professionalism. Mental hygiene, of course, was a diffuse and contradictory term that both promised mental health and strengthened the theoretical foundation of the eugenics movement. But at its core, and in the wake of public alarm about the rates of psychiatric issues identified in the First World War's draft screenings, it promised the prevention of almost hopelessly untreatable mental diseases through strategic behavioral changes such as carefully thought-through techniques of habit formations in children, and intelligent parenting that would provide neither too much nor too little affection.[60] Indeed, the interwar period's shift of the mental hygiene movement from asylum-based psychiatric practices to public health forced nurses and social workers to rethink both their disciplinary practices and their relationships with each other. Social workers, not nurses, had developed the "casework"

method for systematically understanding an individual in the context of his or her environment.[61] But nurses, not social workers, had the experience and the expertise in the kinds of neighborhood engagement and outreach necessary for widespread mental health education and treatment.

This "new approach" to public health nursing practice incorporated both the techniques of casework and the nurses' long-standing skills at engaging parents of physically ill children as the best way to reach a child with emotional problems. This put nurses in an acknowledged competition with social workers. In New York City, Harry Hopkins, then with the New York Tuberculosis Association, and Bailey Burritt, the general director of the AICP, conceded physical health and welfare to the East Harlem demonstrations, but they had both hoped that the Bellevue-Yorkville Demonstration would establish the ascendency of social workers in family health work. But, a 1922 editorial in the *American Journal of Public Health* warned social workers that health—both of an individual and of the public—remained the single most important factor in all social work practices, and ill health was the most important cause of poverty and of the "maladjustments" it engendered.[62] This position strengthened the hand of public health nurses who took power from their command of medical science. And nurses used this power. As Elizabeth Anderson, a psychiatrist and consultant to the Bellevue-Yorkville Demonstration, looked back and wondered why cooperation so often failed to take root between public health nurses and social workers, she chided that nurses might remember that they "do not have the final and only right answer."[63]

It fell to Sybil Pease, a social worker and mental hygiene consultant to the Nursing Service, to describe how nurses managed this interdisciplinary new approach to family nursing in a series of journal articles and reports to the Rockefeller Foundation. There was, she acknowledged, the problem of "double identification." A social worker working for a public health nursing agency needed to be able to accept nurses' own use of social casework methods "with equanimity and a minimum urge to change it except as it becomes ready to change itself in its own way and in its own time." As an aside, she added, "in her most optimistic moments she would never have imagined beforehand finding a group in another profession with which she would be so proud and happy to be identified."[64] Pease carefully drew practice boundaries around only a particular group of nurses—public health nurses—who could encroach on the social workers' territory. She mitigated conflict by declaring that the public health nurse was, in fact, a new kind of social worker. Her place in the community stood between caseworkers, who diagnosed and treated the environmental ills that led to serious delinquency and psychiatric illnesses, and settlement

house workers, who developed educational and recreational activities for groups in their particular neighborhoods.[65]

It did, Pease acknowledged, take some "working out" to arrive at this role definition. The initial East Harlem Nursing and Health Demonstration Project, under pressure from the National Committee on Mental Hygiene, had first tried to establish a traditional mental hygiene service to meet the needs of the neighborhood. Several afternoons each week a team consisting of a psychiatrist, psychologist, nurse, and social worker would meet with "badly adjusted" individuals and families for diagnosis and ongoing treatment.[66] This proved problematic: The public health nursing staff spent an inordinate amount of time with the identified "problem" child, leaving little time for the community-based family education work also expected of them. By 1930, the Service decided, instead, to concentrate its nurses' work on issues related to mental health promotion and the education of women and, through them, their families. Their research agenda shifted to identifying the knowledge and what they believed to be the social power to be gained from working with well-adjusted families. This included identifying the mental hygiene issues of pregnancy; charting the emotional growth of young people; and developing sex education resources for parents and children.[67] As Pease explained in an accompanying article, East Harlem nurses drew from their long tradition of health education work and reframed their prolonged contact with a mother—from her first prenatal visit through her child's entering school—as a unique opportunity to support mental as well as physical health.[68] Families struggling with issues of severe mental "defects" or disorders would be referred to other social service agencies.

Two additional threads consistent with the mental hygiene movement ran through East Harlem's new approach to family nursing. First, there was no longer any notion of a "normal" family. The pervasive idea of "adjustment" as a signifier of mental health and illness also held it to be but a matter of degree, and that "to be normal is to have a problem of adjustment to work out."[69] All families needed mental hygiene help. In fact, to be "normal" was to be in need of advice "about innumerable things from a friendly person in whom one has confidence."[70] And patients, sometimes termed pupils, would necessarily have that confidence in one who nursed the sick when she returned to tell an expectant mother about infant care feeding and the best weaning practices that would encourage both excellent nourishment and emotional independence.[71]

The second thread consisted of the intense scrutiny expected by the nurse of herself as well as the family in her care. To be more "objective"—to have the capacity to deal with a family's situation without allowing her judgment to be affected by emotions, assumptions, biases, or preconceived notions—she had

to constantly examine her own thoughts and feelings. Indeed, the nurse had to be open to the pain as well as the joy of her own emotional life so that she could accept that of others.[72] One important role of the mental hygiene consultant, Pease concluded, was helping the nurse perform a sometimes painful self-examination.[73]

The stakes seemed high. By the early 1930s, Bunds had appeared in German neighborhoods in Bellevue-Yorkville, marching in support of Adolf Hitler; uptown in East Harlem, Fascist rallies and newspapers extolled the leadership of Italy's Benito Mussolini. As Pease said upon concluding her speech to public health nurses in Canada in 1934, the public health nurse directly affects the process of family-building. And in a successful family, "people who have known love and security and a chance to be independent in their first years are not likely to become insane or neurotic as adults; and because happy people do not commit crimes nor does a contented nation make war."[74]

This "new approach" was not easy to learn. As Grace Anderson wrote to Mary Beard in 1936, "the helplessness of many students when deprived of their basic nursing skill is evident." Beyond suggesting attending the Service's clinics, most students were "at a loss as to how to proceed" when in the mothers' homes. In addition, "they expect results to follow quickly on their 'advice.' If the mother accepts advice and results follow, the average student sees nothing beyond an immediate correction. If advice is not accepted, then there is nothing to do because 'I've told her, and she won't do anything about it.'"[75] The challenge was in creating a new worker who understood the "principles" that caused such seeming "non-cooperation," the "reasons" for all behavior that seemed "indifferent, unintelligent, or even vicious on the part of parents," and the ways in which such knowledge could construct a more helpful approach to the family.[76] This would be one who struck a "desirable balance between the passive approach of a social worker and the authoritarian methods of the average nurse."[77] Even in practice, the constant balancing between physical and mental healthcare demanded by the "new approach" proved difficult.

East Harlem nurses were not unique in their need to establish role boundaries with social workers. Between 1931 and 1932, a joint committee of the National Association for Public Health Nursing and the American Association of Psychiatric Social Workers met to consider the role of the mental hygiene consultant in public health nursing agencies. A consensus emerged that the idea of integrated mental hygiene nursing practice rather than a separate mental hygiene clinic allowed for flexibility and the ability of individual agencies to experiment with operationalizing its practice. Ideally, at East Harlem, the nurse would teach content woven from nutrition, medicine, habit training, and

education and allow her carefully developed relationship with the mother to carry the message.[78]

Still, the issue of the problematic nature of the relationships among public health nurses and social workers rippled across the East Coast cities fortunate to have relatively large numbers of public health nurses and social workers. A 1928 study of the relationships between public health nurses and social workers in Boston found 15 percent of the cases that required collaboration "problematic." Some involved issues about which little could be done, particularly those involving high levels of turnover among clinicians. Most others, however, involved unresolved tensions between social workers disregarding nurses' intimate knowledge of the families they referred and nurses not appreciating the time social workers had to take to ensure the right kinds of material and emotional relief needed.[79] The year 1929 saw the report of the Committee on Psychiatric Social Work in Public Health Nursing Agencies, commissioned by the American Association of Psychiatric Social Workers, in conjunction with Henry Street's VNS, the AICP, the East Harlem Nursing Service, Chicago's Infant Welfare Society, Minneapolis's VNS, and Boston's Community Health Organization (that city's VNS equivalent). This report confirmed the possibilities and the problems of relationships among nurses and social workers.[80] By 1930, the relationships between both groups were characterized as that of "stepsisters"—alliances of divergent individuals rich in possibilities but dependent upon flexibility; indeed, social workers felt that nurses were "too sentimental" and nurses found social workers too objective.[81] By 1931, Burritt had commissioned a study at the AICP to determine if one worker—trained as part nurse and part social worker—might be a viable alternative. He wanted to again test the waters by introducing the European notion of the "health visitor" into the American healthcare landscape.

The idea of a health visitor had reemerged in 1925, scarcely two years after the Goldmark Report emphasized the need for a fully trained nurse to engage in public health nursing. The British Royal College of Nursing received government approval to establish a standardized training course for health visitors, and local health districts began offering them more secure employment contracts than those received by trained nurses working in the community for philanthropic organizations. This British precedent seemed attractive to the social work reformers leading New York City's two demonstrations projects. Burritt and Kingsbury, in particular, lionized the role Sir Arthur Newsholme, as medical officer of the Local Government Board in Whitehall, played in expanding the role of the state in providing both preventive health services and actual medical care. England had long been viewed as the "birthplace" of modern public

health nursing. But by the early 1930s, when social workers looked at the idea of health visitors with interest, US nurses looked on, some with trepidation and others with disdain.[82] Alma Haupt, the director of the AICP's Bureau of Nursing, wondered "Whither Nursing" in a 1929 memo to Burritt. Her nurses, she wrote, would be happy to leave the AICP's service if the Association provided better-educated social workers than it presently had.[83] Marguerite Wales dismissed the idea. In England, unlike in the United States, she wrote in the pages of *Public Health Nurse* in 1930, a public health nurse might mean a graduate of a specialty institute with impeccable educational credentials, a graduate of a training school with or without additional midwifery training, a village nurse midwife with only a few months of hospital training, or a health visitor.[84]

Looking Forward

Little came of this proposal. The Depression hit New York City and the world, at first slowly and then with blazing speed, bringing to a halt any thoughts of experimentation or demonstration. Nurses (those that were left after budgets were slashed in both the Department of Health and private agencies) had to nurse; social workers (seeing their ranks expanded by less well-trained men and women) had to determine relief eligibility; and the heads of the most prominent social welfare agencies had to reconfigure their diminished roles as first the state and then the federal government assumed responsibility for direct financial relief. The early 1920s nightmares of six or seven workers descending on one family ceded to those of trying to find just one worker to address crushing needs.

Still, the nurses at the East Harlem Nursing and Health Service remained resolutely optimistic and secure in their new knowledge claims as they looked to their future. They hoped their claim to interdisciplinarity would eventually engage the Rockefeller Foundation. The Foundation was, in fact, very interested in interdisciplinarity and in the late 1920s had begun funding an increasingly coherent program of research that focused on the "science of man" and called for "fearless engineering" to integrate the social sciences with the biological, medical, and natural sciences. The results established the legitimacy of social science as an academic discipline and eventually lay the foundation for a new field of science: molecular biology.[85] But, however fearless, this program of research centered on a particular vision of science that assumed a reductionist stance: that one could isolate and measure discrete variables likely to have the most significant impact. As Ellen Lagemann had argued, this inherently gendered stance blinded Foundation officials to alternate modes of inquiry that might focus on more inclusive, comprehensive, and responsive attempts

to employ a more multifaceted approach. They dismissed all other research as "propaganda" by well-meaning but pre-professional (usually) women.[86]

These nurses and their allies also remained convinced they could breech the layers of distrust that East Harlem families held for other workers who would tell them how to live their lives and raise their children. They placed great faith in the premise that the needed bedside care they provided to families in times of illness would translate into families' confidence when they returned to teach the new message of health. They recognized they were not a complete "family nursing service." The nurses in East Harlem, unlike those working for the city's Health Department in the Bellevue-Yorkville demonstration site, had no access to children in their neighborhood schools that were playing an increasingly important role in the circulation of messages of health and hygiene. They nevertheless believed that their approach to teaching mothers about their entire families' health needs would spread their influence even to these children.[87]

As it looked to the future, Anderson and her colleagues remained committed to forging "a new approach" to formal public health nursing practice. But they also looked to take a more visible leadership role in public health nursing education. The nurses at East Harlem still hoped to forge a unique and model relationship with Teachers College at Columbia University for the postgraduate education of diploma-trained nurses who sought public health nursing positions.[88] They also wanted to take curricular leadership in public health nursing and fundamentally change the way nurses thought about their patients and their patients' needs.